PA11-2004: FUZEON REQUEST

RI MEDICAL ASSISTANCE PROGRAM
PRIOR AUTHORIZATION REQUEST FORM

NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

FAX TO:
DEPARTMENT OF HUMAN SERVICES
ATTN: PHARMACIST
401-462-6336

PRIOR AUTHORIZATION NOT REQUIRED FOR RECIPIENTS UNDER 21 YEARS OF AGE.

CLIENT NAME _____ DOB: _____ MEDICAID ID NUMBER: _____
PRESCRIBER NAME: _____ PRESCRIBER DEA #: _____
PRESCRIBER OFFICE ADDRESS: _____
_____
OFFICE PHONE NUMBER ( ) _____- _____
REQUESTER NAME: _____ RN /MD /R.PH / ____
PHONE NUMBER ( ) _____-_____ FAX NUMBER ( )_____-_____
DRUG REQUESTED : _____QTY / FILL _____

CRITERIA SPECIFICATIONS ARE AVAILABLE BY CALLING **(401) 784-8100** OR AT WEB ADDRESS
www.dhs.ri.gov/dhs/heacre/provsvcs/mpharpa.htm

DOES THE PATIENT HAVE A DIAGNOSIS OF HIV? YES / NO

IF YES, PLEASE INDICATE THE DIAGNOSIS WITH APPROPRIATE ICD-9 CODE. ICD9 CODE _____

IS PRESCRIBER IS A SPECIALIST IN INFECTIOUS DISEASE? YES / NO

DOES THE PATIENT HAVE PERSISTENT VEREMIA WITH CURRENT DRUG TREATMENT? YES / NO

IS THE PATIENT CURRENTLY ON THREE (3) ANTIRETROVIRALS? YES / NO

IF YES, PLEASE LIST?

HAS THE PATIENT FAILED ON GREATER THAN SIX (6) DIFFERENT ANTIRETROVIRAL DRUG THERAPIES (EQUIVALENT TO TWO (2) ARV COURSES OF TREATMENT? YES / NO

COMMENTS:

PRESCRIBER SIGNATURE _____ **DATE** _____
By Signature, the Prescriber confirms the criteria information above is accurate, verifiable by client records and available for review upon request.

PA # _____ **APPROVED**_____
DENIED _____
PENDING ADDITIONAL INFORMATION_____
DATE /TIME OF RECEIPT _____
DATE/TIME RESPONSE _____
REVIEWER _____
COMMENTS:

DHS RI PRIOR AUTHORIZATION
FAX NUMBER 401-462-6336